

**CASE STUDIES  
OF  
MOSQUE AND CHURCH CLINICS IN CAIRO, EGYPT**

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**For USAID, Egypt**

**December, 1994**

## **ACKNOWLEDGMENTS**

The author wishes to acknowledge the support provided by Dr. Hamdy Sayeed, Dr. Sameh El-Gayar, and Mellen Tanamly during the study. Thanks are due to the clinics who participated in the study, some of whom gave generously of their time and help. Able interpretation and research support was provided by Basma Osama.

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## **GLOSSARY**

DOP	Directorate of Planning (in Ministry of Health)
MOH	Ministry of Health
MOSA	Ministry of Social Affairs
CCO	Curative Care Organization
HIO	Health Insurance Organization
LE	Egyptian Pounds
OPD	Outpatient Department
STI	Sexually Transmitted Infection
ALOS	Average Length of Stay

Current exchange rate LE 3.5 = US\$1

## **EXECUTIVE SUMMARY**

The overall purpose of the study was to systematically document the experiences of mosque and church health facilities. The study aimed to develop a number of case studies which explored the types of health services provided by religious organizations, the clients they serve, the quality of care provided, doctors employed and the method of payment, and costs and financing of services.

A number of different research methods were used. This included interviews, observation, and record analysis.

The study encountered a number of problems. This included clinics refusing to cooperate in the study after initially agreeing to do so, and clinics withholding certain types of information. Recognizing that this was difficult research terrain, the research strategy was changed, and the scope of work reduced.

The study indicated that religious health provision is not a new phenomena in Egypt. Mosques and the Coptic church started health activities in the '70s. The growth does not appear to be related to the recent rise in Islamic fundamentalism in the country.

Health is just one of the social services provided by religious organizations. Mosques and churches must register a society with the Ministry of Social Affairs before starting services. Societies providing health services are required to obtain a license from the MOH and Medical Syndicate. Until fairly recently the MOH and Medical Syndicate did not play a very active role in monitoring the sector. This has increased somewhat, and both organizations now visit facilities prior to granting a license. MOH officials acknowledge the importance and contribution of the sector in health.

The case studies show that mosque and church clinics fill an important gap between high cost private health care, and poor perceived quality of public services. They largely succeed in providing quality health care at low cost.

Health services comprise polyclinics which provide outpatient consultation in different medical specialties. This degree of specialization is not needed at this level of the health delivery system. Some clinics provide inpatient services. However, generally the occupancy of hospitals is not very high.

They possess varied diagnostic capacity. On the whole they possess equipments that are appropriate to their needs. Only one of the clinics had an x-

ray machine. The others had made special arrangements with outside private x-ray facilities. However, the hospitals aspire towards acquiring more sophisticated equipment.

There is multi-sector employment of doctors in Egypt. Most doctors working in mosque and church facilities have jobs in the public sector. Some are also employed in the for-profit private sector, and some may even have their own private practice. Doctors work in clinics because they can serve the poor, improve their income, and gain work experience and exposure.

Clients' perceptions of quality of care is very high, and they are extremely satisfied with the service. The main reasons given for using the services are low price, convenience and quality.

Mosque and church facilities have two main sources of income, donations and fees. Fee levels are nominal. Zakat or religious alms appears to be an important source of income for mosque societies. All clinics exempt fees for patients who can't afford to pay them.

Fee revenue in some cases is sufficient to cover operating costs, but in other cases it is not. Donations meet recurrent deficits, and support all capital costs. The funding base of societies seems fairly stable.

The sector represents an additional resource for the health sector. Although possessing certain weaknesses such as an inappropriate degree of medical specialization and almost exclusive curative focus, mosque and church facilities are extremely popular and accessible to the poor. Considerable scope exists for strengthening the sector, and for exploring further the potential for supporting similar private sector health initiatives in the country.

## INTRODUCTION

The overall purpose of this study was to prepare several case studies exploring the factors leading to the success of urban mosque and church clinics in Cairo. Religious organizations play an important role in health provision in the city. Furthermore, they are widely perceived as popular and successful examples of the development of private sector health care organizations which provide health services to a population including working class and poor patients.

However, to date, available information on the sector has been anecdotal in nature. The goal of the studies was to systematically document the experiences of several of these organizations in providing health services. They investigate the size and scope of the sector, services provided, clients served, and costs and financing of clinic services.

Specifically they aimed:

- (1) to assess the role of the facilities in health service provision in the context of the larger health system in Cairo.
- (2) to assess the organizational and financial sustainability of the health facilities.
- (3) to assess the impact of the facilities on provision and utilization of health services in the city.
- (4) Based on the study findings, to explore the feasibility of replicating these facilities as a form of private sector health provision serving a low-income population in other urban settings in Egypt.

The study planned to undertake a total of four clinic case studies. This included 3 mosque clinics and 1 church clinic. Clinics were selected with the help of the chairman of the Medical Syndicate. It was hoped the overall sample would reflect a range of geographical locations in the city, and a range of the types of health services provided, eg. inpatient/outpatient, levels of sophistication, etc. A combination of both qualitative and quantitative data was to be collected, employing a number of different research methods. This was to include:

- (1) Interviews with a range of organizations and individuals, including government officials, mosque and church clinic staff and management, society members, clinic clients, and other health providers in the vicinity.
- (2) Direct observation in the clinics.



- (3) Internal clinic service registers, pricing and billing records, patient medical records, financial records.
- (4) A client survey, development of several client case studies based on a sample of client interviews.

The study took place over a period of 7 weeks.

However, a number of problems were encountered during the course of the study which did not allow the full study objectives to be fulfilled. The first main problem was that some clinics who had agreed to participate in the study subsequently turned around part way into the study and refused to cooperate further. The second main problem concerned information. Clinics were unwilling to provide certain types of information. There was particular reluctance towards providing information related to financing and costs of services. Some clinics refused to supply data related to service users, such as number of outpatients, or length of stay, etc. This was despite the fact that the objectives of the study and information needed was clearly explained to them at the start.

As a result of these problems some of the clinics had to be dropped entirely from the study, and at others the study had to be reduced in scope. As a result of the similar problems encountered at different clinics and an acceptance that this was difficult research terrain, it was agreed that the scope of work and study approach change (see Annex 2 for original scope of work). It was thought that a better strategy would be to approach clinics and ask them what types of information they would be able to supply. This was the strategy that was adopted for the remaining clinics. If clinics did not feel comfortable giving certain information, it was dropped from the study. This has resulted in a range of different information on the participating clinics. It is felt that although certain details are still not known about mosque and church health facilities, a greater understanding of the sector as a whole has been achieved.

The problems also resulted in all study clinics being located in one area of Cairo. This was because the chairman of the Medical Syndicate who helped in the selection has considerable influence in this area, and it was hoped that this would facilitate the study. Annex 3 describes in some detail the problems encountered, as well as the possible reasons for the difficulties.

The first part of the report provides a background to the religious health sector in Egypt. The section discusses the history and development of the sector, its size and scope, as well as government perceptions of health provision by religious organizations.

The second part of the report presents 4 individual case studies of religious

health facilities. Three are run by mosque societies and one by a church society. They vary in the types and depth of information they contain since some societies were not willing to provide certain types of information. The fourth case study - Emad El-Dean contains very limited information and analysis since this study was terminated after the first week. Other case studies present information on the management structure of religious societies, health services provided, doctors employed and their method of payment, sources of income, system of charging adopted, exemptions provided to the poor, patient perceptions of quality of care, and an assessment of the financial status of the health facility.

The last section of the report summarizes the main findings of the studies. It draws some preliminary conclusions on the strengths and weaknesses of the religious health sector, their impact on other providers, and finally makes a tentative assessment of the desirability and feasibility of replicating this model of private health care provision.

## **BACKGROUND: RELIGIOUS HEALTH SECTOR**

### **History, Growth and Development of the Sector**

Health service provision by religious organizations is not a new phenomena in Egypt. The church, mostly protestant and Catholic denominations, has a long tradition of providing community services, such as health and education. The Coptic church and mosques have more recently followed their example. Health provision by mosques and the Coptic church can be traced to the early '70s. Services were started against a backdrop of worsening economic conditions in the country. Costs of private health care were rising and becoming increasingly more inaccessible to the middle class, while government health services were perceived to be of very poor quality. It was in this context that religious organizations started services to meet the health needs of middle and low-income population. They aimed to provide good quality health services at low cost.

Health care is just one of the many social services provided by religious organizations. Other activities include, running nurseries, literacy classes, social clubs, services for the elderly, and vocational training.

The growth of these organizations appears to be unrelated to the recent rise in religious fundamentalism in the country.

### **Status, Regulation and Monitoring of the Sector**

Mosques and churches wanting to provide social services are required to register as a society with the Ministry of Social Affairs (MOSA). Registration with MOSA gives them non-profit status and entitles them to tax exemption. However, they are still liable to pay income tax on behalf of the staff working in their facility. The societies are required to submit annual audited accounts and other service related information to MOSA<sup>1</sup>.

Societies wanting to provide health services, both inpatient and outpatient, are required to register with the MOH and the Medical Syndicate. The latter is the professional association of medical doctors. Both these bodies request that a minimum standard of service be reached before granting a license; for example, that health facilities possess certain equipment and commodities, that hospitals have a generator etc. Initially the Medical Syndicate was not that pro-active in inspecting facilities before giving a license. However, since the last 4 to 5 years their administrative capacity has increased and they now visit facilities to ensure

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<sup>1</sup> MOSA is a potential source of data for a future study of Mosque and Church facilities in Egypt.

that they meet minimum requirements.

Regulation and monitoring of religious health providers, as of other private health providers is undertaken through the Medical Syndicate. It is therefore a system of professional self-regulation. Effectively this means that monitoring is undertaken only in response to complaints and grievances of patients, for example in the event of a death.

Although they are required by law to register with both MOH and MOSA, many societies have not. Recently, there have been a few instances when facilities not possessing a license have been closed down as a result of a complaint or other incident.

### **Information on Current Size and Scope of the Sector in Cairo**

As mentioned, mosque and church societies providing health services are required to register with MOSA and the Medical Syndicate. Therefore in theory it should be possible to estimate the number of such societies and hence the size and contribution of the sector. The consultant asked the Medical Syndicate to provide information on the number of registered religious societies providing health services. However, this was not possible since registration is undertaken on the basis of name only. It is not always possible to identify a mosque or church society by the name alone.

However, anecdotal evidence suggests that the religious health sector makes a significant contribution to the health sector in Cairo. One official from the Medical Syndicate feels however that the sector has now reached saturation. Further he felt that the mushrooming of mosque and church health facilities has resulted in significant hardship to private doctors, since many of their patients have switched to the religious sector. There are many instances of private practitioners having closed their practices in the vicinity of a mosque or church facility.

### **Perceptions of, and Support Provided by Government and Specifically Ministry of Health**

Societies do not receive financial support from government. They are eligible to receive some support from MOSA, but in reality none of them do. MOH officials acknowledge the importance and contribution of the sector in health. At the same time they accept the need to regulate and monitor their activities more closely.

There is a very strong link between the public and religious health sectors in that

many doctors employed in the public health sector also work in mosque and church facilities.

### **Financing of Mosque Societies**

A special section is included here on financing of mosque societies because of the system of "zakat" or the giving of alms in the Muslim religion. Muslims are required to give a minimum of 2.5% of their remaining annual income (i.e., surplus of living costs) towards support of the poor in the community. Individuals give zakat in many different ways. They may give money directly to the poor; alternatively, they may give to a mosque, or to a social welfare organization.

Each mosque has a zakat committee. The zakat committee maintains a register of poor families in the community to whom they give financial support, e.g., widows, the disabled, orphans, etc. The zakat committee may also give funds to the society to support health and other social activities. Alternatively, people may give zakat directly to the mosque society. In addition to zakat, mosque societies may receive "other donations" from individuals. Therefore zakat maybe one form of donation that the religious societies receive.

Nassar Bank, which is the bank affiliated to MOSA, maintains a register of zakat committees. The bank has access to zakat funds. It is responsible for giving low interest loans to individuals and organizations for social purposes. In theory mosque societies are eligible to tap this fund as well. In reality few of them do.

In contrast to MOSA, there is a Ministry of Awkaf or Endowments which is responsible only for the religious affairs of the mosque.

The land on which mosques are built are owned by the local council (elected local government body). Local councils charge mosques a token annual rent of LE 1.

## **CASE STUDIES**

### **1. Gamal El Dean Aphgany Hospital, Medan El-Gamme, Heliopolis**

#### ***Background:***

Aphgany hospital is located in Heliopolis, a large residential suburb of Northern Cairo. Within Heliopolis it is situated in the centre of a busy commercial area. The hospital occupies a building attached to the Medan El-Gamme mosque. The hospital is thus physically a part of the mosque and its complex of buildings.

The Medan El-Gamme mosque formed and registered as a society in 1982. In the same year, the society opened an outpatient clinic or "polyclinic" in the mosque premises. Almost immediately, they began to raise funds for the construction of an inpatient facility. The hospital was opened two years later in 1984.

The society say they opened the health facility in response to a felt need for accessible, low cost, high quality health services for low income people living in the area. There were many private practitioners working in the locality at the time, but their services were inaccessible to the poor. Furthermore, they felt that the local public facility - the Heliopolis Hospital owned by the Curative Care Organization (CCO) was crowded and of poor quality. Therefore, Aphgany hospital can be said to have been set up with the aim of filling a gap between the two health sectors - private for profit and public. It's main clientele, however were to be those of low income.

The hospital has expanded gradually over the years. The hospital and polyclinic together currently occupy 4 floors of the mosque building. The administrative offices of the society are located on the top floor of the same building.

The society provides a number of other community services apart from health care. For example, on the mosque premises they run a nursery, a library, a building for religious and social celebrations, and a social Islamic club. In addition, they provide burial services, and organize religious pilgrimage (Haj) to Mecca. The society has a shop in the "gamme" or mosque square which retails hand-made goods. This enterprise aims to generate income for local people. The society also provides direct financial assistance to the poor, mostly the disabled, widows, and the elderly.

#### ***Organizational Structure and Management:***

##### *Management structure*

The hospital is directly accountable to the mosque society. The society comprises an elected body of 15 executive members. These members are elected by the society's 225 members, who each pay an annual membership fee of LE 3. The society is responsible for making all planning and management decisions related to the hospital, for example, hiring of staff, purchase of equipment, setting fees levels, etc. The society is also responsible for financial management of the hospital, such as fund-raising.

A hospital administrator is responsible for the day-to-day management of the hospital. He is assisted on technical matters by a hospital director. The hospital administrator also happens to be one of the 15 elected society members. The elected society members are unpaid volunteers. They are either retired or have other full-time jobs, with the exception of the hospital administrator who is a full-time salaried member of staff. The hospital director also receives a salary, but works on a part-time basis. He holds a post at a university hospital in Cairo.

In addition, the society has a number of paid administrative staff. This staff are responsible for administration of all society activities, including the hospital. For example, a financial supervisor is responsible for the financial management of the hospital and other society activities such as the nursery and shop. The society staff occupy an office on the top floor of the hospital building.

The hospital administrator is directly assisted by a small team who mainly provide clerical support, e.g. record keeping, billing, etc.

### *Supervision and monitoring*

The hospital maintains very few records. Services are monitored however, in terms of throughput, e.g., numbers of outpatient contacts, number of inpatients, and operations performed in a month, etc. The hospital does not explicitly monitor the quality of care provided, although the hospital administrator together with the hospital director do periodically monitor staff performance. For example, drugs prescribed to inpatients, and supplies used in a surgical procedure.

### *Staff:*

The hospital currently employs 40 doctors of different medical specialties and 10 nurses. All clinical staff, are employed on a part-time basis. With the exception of 3 nurses, they all hold "full-time" posts in public health facilities. This includes government, university teaching, and military hospitals. Some doctors hold a third position in a private hospital, such as Nassar International. A few also have a private practice. Therefore, at a minimum, doctors are simultaneously working in at least two sectors - public and religious sector. Sometimes they may even

work in a third sector - the private for-profit sector.

The number of days in a week a doctor works at the mosque facility varies according to the need for the specialist on a particular day and the availability of the doctor. However, on average each doctor works 3 mornings or evenings a week. The outpatient clinic is busiest in the evening. Therefore, on any given evening the clinic is open, most medical specialties will be available.

Nurses work either 12-hour or 6-hour shifts. For example, the head nurse works from 3:00pm to 9:00pm six days a week. She also works 5 days a week in the military hospital, where her official hours are from 8:00am to 1:00pm.

Medan El-Gamme mosque society has a policy of only employing Muslim doctors and nurses. They say that the only reason for this is because workers can "fit" into the working times of the hospital.

### *Staff qualifications*

The doctors employed in Aphgany hospital include university professors, consultants, assistant consultants, specialists and a few general doctors. They comprise all ages and levels of experience, ranging from newly qualified doctors to senior consultants. The general doctors work in the emergency outpatient clinic. This operates outside of clinic hours. Most of the general doctors working in the mosque clinic are studying for further specialized degrees, and choose to work in the mosque clinic for work experience outside of the government teaching hospital. Some of the doctors are doing their military service. It is compulsory for doctors in Egypt to do two years of service, usually in a military hospital. Most doctors opt to do the military service after completing their specialist training.

### *Staff payment*

It was mentioned that hospital administrative staff are full-time employees and receive a salary. In addition, the hospital director who works on a part-time basis is paid a salary.

All other doctors are paid on the basis of the number of patients they see. In the outpatient clinic, specialist doctors receive 40% of the consultation fee charged to patients. The OPD consultation fee is currently LE 3, therefore the doctor is paid LE 1.20 for every patient treated. The general doctors working in the emergency outpatient department receive 25% of the OPD emergency consultation fee, currently LE 3.50. General doctors therefore receive LE 0.87 for every patient they see.



Surgeons receive 25% of the total operation cost. Inpatients are charged a fixed amount for their surgical procedure and hospital stay. The charge depends on the complexity of the procedure performed. The assistant surgeon receives a fixed amount of LE 4 for every procedure, regardless of its complexity.

Nurses are paid a salary according to the shifts they work. For example, a nurse who works a six- hour shift for six days a week receives LE 180 per month, while a nurse who works a 12-hour shift is paid LE 225 per month. In addition, nurses are paid incentives and can increase their take-home pay by doing regular overtime. A nurse assisting in a simple operation is given LE 1, and LE 3 for assisting in a major operation. An assistant nurse whose responsibilities include taking blood samples and giving injections receives a monthly salary of LE 90.

The potential earnings of both doctors and nurses at Aphgany hospital are significantly higher than those in the government sector. For example, a nurse working in a government hospital receives a salary in the range of LE 50 to LE 120 per month. This compares to an income of LE 90 - LE 180 in the mosque facility.

On average, a specialist doctor at the Aphgany polyclinic sees about 25 patients in an evening session. This represents an income of LE 30 per session. If he/she works 3 evenings a week, this implies a gross monthly income of LE 360, while a specialist doctor employed in a government hospital receives a basic monthly salary of LE 150. A general practitioner working in the mosque's emergency outpatient department sees approximately 20 patients in a day. With an income of LE .87 for each patient, he/she may take home approximately LE 82 per month. A general practitioner in a government hospital earns approximately the same, LE 80 a month.

It is more difficult to estimate the income of a surgeon at the mosque clinic, since the number of operations they perform vary considerably. However, they do also undertake outpatient consultations, so their potential to earn is greater than the specialist non-surgeons. Viewed in which ever way, the income of both doctors and nurses at the mosque clinic serves as a substantial supplement to their government salary.

#### *Staff motivation and turnover*

"Service to the community" and "to serve the poor" were the two main reasons given by doctors for working in the mosque health facility. Many doctors specifically said that it was a part of their religion to serve the poor. They gained considerable satisfaction from working in the clinic. Another reason given more by the younger doctors was to gain experience and establish a name or "gain

fame". They felt that working in the mosque clinic would help them set up a private practice in the future.

Although not mentioned explicitly by any of the doctors, the income they earn at the Aphgany hospital must also be a strong motivating factor. As estimated above, it represents a significant supplement to their government salary.

Not surprisingly, the doctor turnover at Aphgany is very low. One member of staff said that "the only time doctors leave is when they go abroad". Even after setting up their own private practice, a few continue to come one or two sessions a week. One doctor routinely spends part of the year working in Europe. However, when in Egypt he works at Aphgany for two sessions a week.

Apart from the personal satisfaction that many of the doctors seem to gain by working in the clinic, they also appear to be professionally satisfied. They like the working environment and are happy with the facilities and equipment available. Despite the fact that the hospital is not as well equipped as many of the government hospitals (especially university hospitals) in which they work, (e.g., there is no CT scan or MRI machine) they like the working atmosphere, and feel that they are able to provide a high quality service.

### ***Health Service Provision:***

The Medan El-Gamme society runs a 30-bed hospital and an outpatient clinic or "polyclinic". This section describes the services provided by each of these units. The diagnostic and pharmaceutical facilities available are also described. A general assessment is made of the quality of care provided based on the general cleanliness of the facility and state of equipment.

#### ***Polyclinic***

The polyclinic occupies the first floor of the hospital building. It comprises fifteen individual consulting rooms. The waiting area runs along each side of the corridor, and can at any one time accommodate about 100 people.

In line with the concept of a polyclinic in Egypt, outpatient consultation is provided in an array of medical specialties. A different specialty is available in each of the 15 consulting rooms. This includes, obstetrics/gynecology, ophthalmology, orthopaedics, general medicine, ENT, paediatrics, dermatology, cardiology, neurology, plastic surgery, chest, rheumatology, gastro-enterology, cancer, and dentistry. The services are wholly curative in their orientation although ante-natal and family planning services are provided by obstetrics and gynecology specialist. Contraceptive services include the oral pill and IUD. These have to be purchased with a prescription at the pharmacy. The clinic does not

undertake child immunization. They feel that this is a government responsibility, and is adequately provided by them. Other child health services are provided by the pediatrician. There are no services for the detection and treatment of STIs. The society does not acknowledge the risk of HIV infection.

The clinic is open from 12:00am to 3.00pm in the afternoon, and 6:00pm and 11:00pm in the evenings six days a week. In reality doctors rarely come before 7.30 for the evening session. An emergency outpatient clinic operates outside of these timings and on Fridays. The doctors on duty in the emergency outpatient clinic make home visits.

Patients are able to make an appointment prior to coming to the clinic. These clients do not have to wait and see the doctor immediately. Most patients however just turn up at the clinic and wait in turn to see the doctor. On arriving outpatients register with the OPD clerk. They pay the consultation fee at this time. Patients either request to see a particular specialist themselves or the clerk assigns them an appropriate specialist based on an assessment of their health problem and symptoms.

No records are maintained on outpatients. Treatment is provided on a purely episodic basis. As a result the doctor has no case history of a returning patient. On registering, patients are given a ticket by the OPD clerk. This contains information on the name and address of the patient, the fee paid and the doctor seen. In fact, it is on the basis of this OPD ticket that doctors are paid. The society does monitor the overall numbers of outpatients seen in a month for the different specialties

### *Hospital*

The inpatient facility occupies 2 floors of the mosque society building. There are a total of 30 beds, distributed over 6 general wards and one 1 private room. A new opthamology wing was recently opened.

Inpatient services are provided in almost all of the above specialties. The hospital has three fully- equipped operating theaters, and a further one is currently being renovated. The hospital conducts fairly simple surgical procedures to quite complex, specialized operations such as eye operations. Deliveries are conducted in the hospital. Sterilization is also undertaken, mostly tubectomy. The hospital performs abortion. It is unclear whether abortion is provided on demand or only for incompletes. It is likely that all are undertaken in the first trimester.

No food is served to inpatients. Patients have to make their own meal arrangements. Typically a relative will bring food to the patient. A relative is also

permitted to stay in the hospital with the patient at a charge.

The hospital maintains better inpatient records. There is a medical record for each inpatient. In addition, an inpatient register is kept which records the length of stay, total cost of operation, and other personal information. The society monitor the total number of inpatients and operations performed in a month according to the complexity of the surgical procedure, e.g. simple, medium or complex.

Sections of the hospital are currently being renovated, and construction work is underway for a new emergency outpatient wing.

### *Diagnostic facilities*

The society has an x-ray facility on the premises and a laboratory which is able to undertake most routine investigations. The hospital also possesses an ultrasound machine. Tests they are unable to conduct on the premises are sent to a private diagnostic facility.

A patient may be referred to a government hospital if they require a more complicated investigation, such as CT scan. Commonly, doctors refer patients to the government facility in which they work.

### *Pharmacy*

There is a pharmacy on the hospital premises. Until the beginning of this year, it was run directly by the mosque society. However, as of January 1st the society contracted out the running of the pharmacy to a private individual. An annual rental charge of LE 50,000 is made for the space. Under the contractual agreement the society is able to enforce a price ceiling on drugs. Drug charges at the pharmacy must be 5% below those of outside neighboring pharmacies. For example, the usual mark up on drugs is 15%, while in the society pharmacy it is 5%. The hospital administrator also has some influence over the types of drugs stocked by the pharmacy.

Most hospital patients purchase their drugs from this pharmacy. It is too early to conclude whether this represents a better arrangement for the society. The LE 50,000 they earn from the annual rental is a significant sum. It is probably more than the income they earned from drug sales when they managed the pharmacy directly. The society is still able to control the prices charged and influence to a degree the drugs stocked.

The drug charges levied by the society when they directly managed the pharmacy is unknown, and therefore it is not possible to say whether this new

arrangement is better from the patients perspective. In a relative sense, patients are still better off buying drugs from the hospital pharmacy than from outside since drugs are 5% cheaper.

It is also too early for the pharmacy owner to conclude whether this is a viable arrangement for him. He said that drug sales are low in comparison to the rental he has to cover. Furthermore, because of the overall low capacity of patients to pay, the doctors in the hospital tend to prescribe "the cheapest drugs".

### *Quality of health services*

The mosque society maintains a good standard of hygiene in the hospital and polyclinic. Wards, consultation rooms and operating theaters look fairly clean and well-maintained. The operating theater is well-equipped. Hospital equipment appears to be in good general working order. The society renovates the facility regularly.

### *Charging for services*

The society charges inpatients and outpatients on a fee-for-service basis. For example, an outpatient consultation with a specialist doctor costs LE 3.00. Follow-up treatment for the same episode of illness within a week costs LE 0.50. A consultation in the emergency outpatient clinic costs LE 3.50. Doctors in the emergency clinic charge LE 10 for a home visit in the locality and LE 20 if further away. Patients are charged for all diagnostic investigations, e.g., LE 10 for an x-ray, LE 25 for an ultrasound, etc. Patients are given a prescription and are able to buy drugs from any pharmacy. However, as mentioned most purchase drugs from the pharmacy in the hospital since drugs are available at 5% discount.

Inpatients are charged a fixed amount related to the complexity of the surgical procedure performed. Operations are classified as simple (with and without anaesthesia), medium, big and specialized. Charges range from LE 100 to LE 500. The charge includes the stay in the hospital. Patients choosing to stay in the private ward are charged an additional LE 40 a day. Relatives of patients staying in the general ward are charged LE 15 a day. The hospital also charges for ambulance transportation.

Inpatient and outpatient charges are the same for adults and children. This is with the exception of tonsillectomy. For a child under the age of 15 years a tonsillectomy costs LE 85, compared to LE 110 for an adult.

### *Exemption of the poor*

The society either reduces or waives fees for non-affording patients. Some of the

outpatients are known to the registration clerk and doctors. The consultation fee is immediately waived for these non-affording outpatients. For other outpatients that claim they are unable to pay the consultation fee, permission has to be sought from the hospital administrator. The hospital administrator may interview the patient to assess their paying capacity.

For granting inpatient exemptions there is a special subsidy committee. The committee comprises three society members, the chairman, the hospital administrator and an elected member. They jointly decide what portion if any of their bill the inpatient will have to pay. A committee member may visit the patient's home to assess their economic condition. They then negotiate with the patient and family what proportion of the total bill they will have to pay.

The subsidy committee has access to a separate fund. This fund comprises of donations specifically made by individuals to support costs of poor hospital patients. In 1993, a total subsidy of LE 8,201 was provided to support the costs of non-affording hospital and polyclinic patients. This represents only 0.62% of total fee income. On the other hand, approximately 10 out of the 500 patients or 2% of patients seen daily in the polyclinic get free care. This may include free diagnostic tests as well as consultation.

### *Fee setting*

The main criteria for setting inpatient fees is cost. The hospital director and administrator jointly decide on the fee level. This is based on the an estimation of the doctors time, supplies to be used and number of days stay. Ability of the patient to pay is also a consideration in fee setting. The health facility was started with the aim of serving the poor in the community, and therefore this is an important consideration. The fees are nominal in comparison to those charged in the for-profit sector. For example, a consultation with a private physician costs anywhere between LE 50 and LE 100. This compares to LE 3.00 at Aphgany. The charges also compare favorably to those charged by the public hospitals, the CCO and HIO facilities. For example, an x-ray at a CCO hospital costs approximately LE 15, compared to LE 10 at the mosque facility.

The outpatient consultation fee has increased nominally over the years. In 1982 when the polyclinic opened the charge was LE 2. It is now LE 3.00. The society is reluctant to raise it further since they feel that it will cause hardship for some in the community.

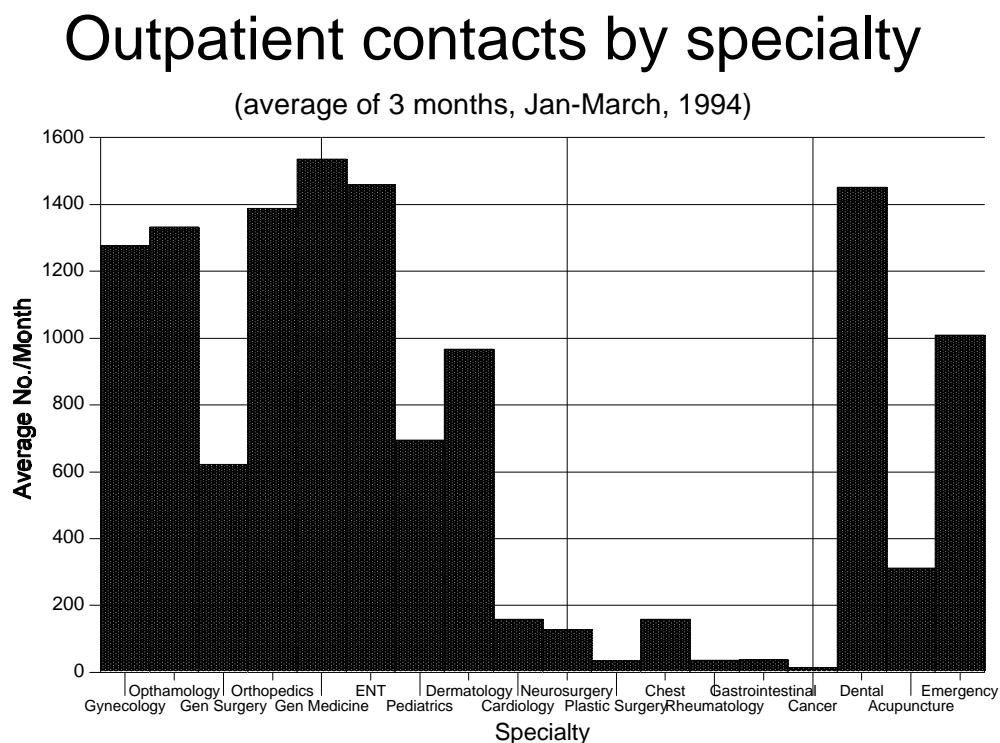
### ***Health Service Utilization:***

This section examines utilization patterns of the mosque hospital and polyclinic. The average number of outpatient contacts and inpatient days in a month are estimated. The study included interviews with a selection of outpatients in order to determine the socio-economic status of service users, to explore the factors underlying their choice of this facility, and lastly, to assess clients' perceptions of quality of care received and patient satisfaction. The main findings of the interviews are presented.

### *Polyclinic utilization*

The majority of polyclinic clients are seen in the evening. Table 1 shows the average number of outpatients seen by the different specialties in a month. The estimates are based on actual contacts during January to March 1994.

**Table 1**



The above estimates imply that on average, the clinic sees 460 outpatients a day (on average 15 doctors are on duty in the evening session). However, this includes the days that the polyclinic provides only emergency cover. If these days are excluded, then on average, the polyclinic sees almost 500 patients daily. There is very heavy use of this facility. Frequently both doctors and patients can be found in the polyclinic at 12:00pm.

### *Inpatient utilization*

Between January and March of this year the hospital had 485 inpatients, or a monthly average of 162. Of the 145 inpatients in March, 15 underwent specialized surgery, 42 major, 51 medium, and 37 simple operations.

The average length of stay (ALOS) of patients is 2.5 days. Therefore, the hospital has approximately 405 inpatient days in a month, or an occupancy of 48%. Unfortunately, it was not possible to make a separate estimation of private ward occupancy.

The hospital has fairly low occupancy. The average length of stay appears to be very short. A recent study estimated ALOS in CCO hospitals in Egypt to be 8.3 days (Health Financing and Expenditure Study in Egypt, Cambridge Consultancy Corporation, 1993). However, some of this difference may be explained by differences in case severity and mix. The bulk of operations in the mosque facility are either of simple or medium complexity, and their ALOS is only 1 to 2 days. There appears to be potential for some surgery to be undertaken on an outpatient basis.

**Table 2**

**Number of diagnostic investigations**

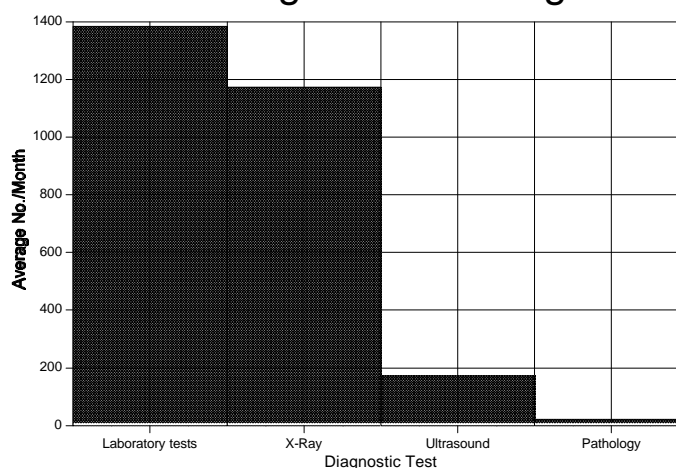


Table 2 shows the average number of diagnostic investigations undertaken between January and March 1994.



### *Patient interviews*

A selection of outpatients were interviewed. The interviews aimed:

- to determine the socio-economic status of clients and assess affordability;
- to explore the factors underlying their choice of the facility; and,
- to assess clients perceptions of quality of care received and patient satisfaction.

Annex 3 includes an outline of the interview schedule. It was initially hoped that the study would also include a larger outpatient survey, which explored a number of user characteristics, such as age, sex, religion, where they come from, income, education etc. This would have enabled a user profile to be established. However, the society did not permit this survey. Instead a number of these areas were explored in the interviews. Questions regarding a patient's religion were not permitted, although this was still assessed indirectly, e.g. from the patient's appearance, whether a veil was worn, etc.

The socio-economic status of patients was assessed on the basis of education and occupation. If they did not work, then on the occupation of husband or father.

The client interviews (see Annex 1 for a selection of interview transcripts) indicate considerable levels of satisfaction with the quality of care provided and prices. There were universal positive responses to questions of staff competence and politeness, clinic opening times, cleanliness, waiting times, etc. The average waiting time was 15 minutes, although one patient waited for 45 minutes to see the doctor. Clients felt that the prices are accessible to almost everyone. They compared the prices favorably to those charged by private practitioners and the nearby CCO facility.

Amongst the reasons given for switching providers, from both public and private sector to the mosque facility were convenience, price, and better quality. One woman who previously consulted a private practitioner said that the doctor "takes more care here and gives her more attention", another "preferred the treatment given". One woman however did say that she would use a private facility if she needed inpatient care. One woman who had brought her daughter to the clinic works in MOSA and is therefore covered by health insurance. She herself visits the HIO facility when ill, but her daughter and husband use the mosque clinic. People do not appear to use multiple sectors simultaneously.

The majority of patients come from the locality. The closest was a patient who lived 3 minutes walking distance from the facility, and furthest a patient who

traveled 30 minutes by bus to reach the polyclinic. Most patients had heard about the mosque facility from friends or relatives who also use the facility.

The interviews suggest that the clinics are serving a wide range of income groups, but that the majority of patients are of middle to low income. Amongst the occupations of patients were fruit shop owner, an office cleaner cum tea lady, and public sector employees. One patient that was interviewed was a free patient. He said he was known by the society. One patient said she could not afford to use private sector.

All patients interviewed were Muslim.

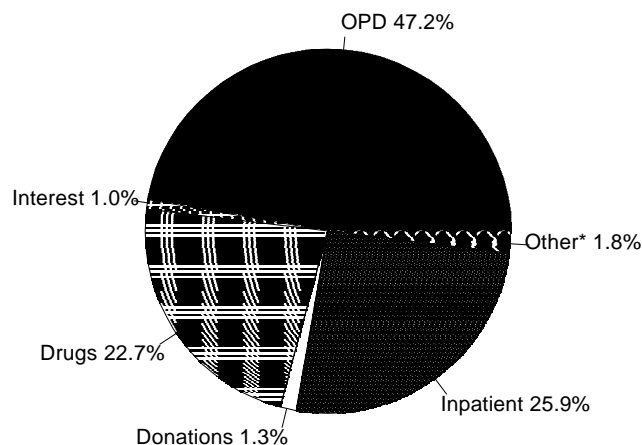
### ***Costs and Financing:***

This section examines the costs and financing of the hospital and polyclinic. Unfortunately, it was not possible to get detailed information related to costs and financing. The society was only willing to provide aggregate expenditure and income data. These are presented.

### ***Sources of Income***

The society has two main sources of income, fees and donations. Donations represent those funds given directly by individuals to the society. They are either zakat payments or additional "other" donations from individuals. The method of charging was explained above. Charges are levied for both inpatient and outpatient services. Last year the pharmacy was run directly by the society. Therefore some revenue was generated from drug sales. Table 3 shows the proportionate income from these different sources in 1993.

**Table 3**  
**Consolidated income by source**



\*

includes membership fee income

Combined fee revenue from OPD, inpatient and pharmacy services represents the bulk of mosque society income. Almost 96% of total income comes from these three sources. Donations represent only 1.33%. The author suspects that the level of donations are heavily underestimated/reported. At the time of study, the hospital was undergoing extensive renovation and expansion. They also planned to purchase new equipment for the hospital. These costs will be met by donations. Volume of income from diagnostic services was not provided separately. It is likely to be included in the outpatient income.

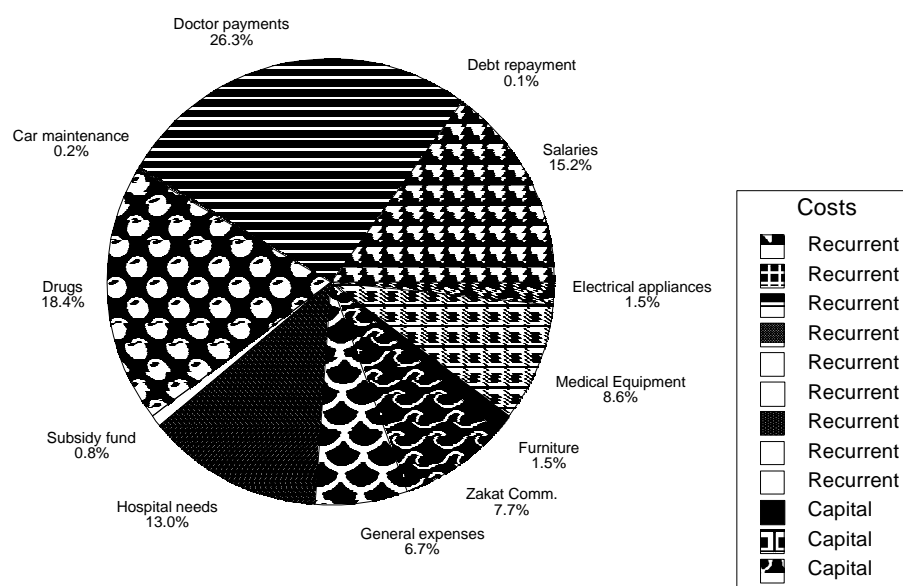
### *Costs*

#### Provider Cost

Table 4 shows the combined breakdown of hospital and polyclinic expenditures in 1993. Recurrent and capital expenditures are shown separately. Recurrent expenditures represent 88% of total health facility cost. Salaries account for the major cost component, at 47% of total recurrent cost. Forty of this represents payments to doctors. Drugs also account for a major proportion, at 21% of recurrent cost. It is likely that some of the salary costs go towards support of

other society activities, such as the shop. Administrative costs are shared by all society activities, but are attributed to the health facility costs alone. Therefore salary costs are an overestimate.

**Table 4**  
**Recurrent and Capital Costs**  
(January 1-December 31, 1993)



In lieu of rent, the society provides a fixed proportion of their income each year to the mosque zakat committee. In 1993, they paid LE 80,401 to the committee. This is in contrast to other mosques clinics who receive zakat funds from the mosque. A total subsidy of LE 8,201 was provided to poor patients last year. This is the fund administered by the society subsidy committee.

### User cost

Direct costs for outpatients include consultation fee, diagnostic tests, and drugs. For inpatients they include the fixed operation charge, diagnostic tests, and drugs. The pharmacist estimates that the average drug prescription amounts to LE 7 to LE 8. The average cost of an inpatient stay is estimated to be LE 118.

### *Financial status (revenue to cost)*

The total recurrent and capital cost of the hospital and polyclinic in 1993 was 1,043,609. In the same year, fee revenue from all sources totaled LE 1,274,858. There was therefore a surplus of LE 231,249 of income over cost in that year. Although depreciation on buildings and equipment was not estimated, one can assume that the surplus was adequate to cover at least part of capital depreciation. Inpatient and outpatient costs were not provided separately, therefore it is difficult to establish the financial status of individual units. Although fee income was adequate to cover all costs in 1993, it is not possible from this to conclude that the health facility is financially self-sufficient. One would need to examine trends in capital expenditures for a few years to before making such a conclusion. Fee income is most certainly covering operating costs. However, it seems likely that major hospital equipment and building is still supported largely from donations.

## **2. St. George Clinic, Heliopolis**

### ***Background:***

St George polyclinic is located in the centre of a main intersection crossing in Heliopolis. The clinic is situated within the St George church complex. The church is just 100 yards from Heliopolis Hospital, the 200 bed hospital run by the CCO.

The church has registered an independent society with MOSA. It is also registered with the Medical Syndicate and MOH.

The polyclinic was opened in August 1989. The idea of the clinic was conceived by the present clinic director. He felt that there were no high quality health services at low cost available in vicinity for the poor. Medical services were becoming increasingly more expensive. Plus the public sector was unable to meet all health needs of people. The clinic's stated objectives are:

- To offer suitable, honest and decent medical services to the public at reasonable or reduced fees
- Provide basic health awareness and guidance on promotion and prevention of ill health.
- To provide give an opportunity to young doctors to serve patients and to help them start their private professional lives.

The polyclinic therefore has multiple objectives. They aim not only to provide health services but also employment opportunities to young doctors. Both curative and preventive aspects of health care are stressed. Interestingly, a separate stated objective is "to offer high quality medical services to our Muslim brothers in the church area to help strengthen our relationship with them".

The clinic originally occupied six rooms in the church building and started out sharing a floor with the library. The library was relocated and the clinic allowed to expand. It presently comprises 12 individual consultation rooms and a dental surgery room.

The church provides other community services. These include a nursery, adult literacy classes, sewing classes, a library, and a youth club. The church also provides financial assistance to the poor.

### ***Organizational Structure and Management:***

#### *Management structure*

The St. George church has registered an independent society with the MOSA. Social activities are run directly by the church society. The society is composed of church clergy and members of the congregation. The pope, or religious head of the church is the head of the society. Each social activity is supervised by an individual clergy member. For example, Father Abraham is responsible for supervision of the health activities. The society holds overall financial and management responsibility of the health facility.

The management structure of the clinic is very lean. The polyclinic director is responsible for day- to-day management. He is assisted by two doctors who work in the clinic. Together they are responsible for making all management and administrative decisions, e.g. setting fee levels, hiring doctors, etc.

There is one accountant for all church community activities.

### *Staff*

There are 35 doctors currently working in the St. George polyclinic. They all hold other jobs in the public and private health sectors. For example, the cardiologist, in addition to working two mornings a week at the St. George church clinic, works a few days a week in a government hospital, a private hospital, and in another Coptic church health facility. The urologist holds a full-time post in a HIO hospital. Some doctors have their own private practice (one doctor had two private practices). The management does not object to doctors having their own private practice.

On average doctors work at the clinic 2 or 3 morning or evening sessions a week. In addition, some provide free services on Monday evenings. This is the day set aside for poor patients. All doctors employed are either specialists or consultants.

The clinic does not employ any nurses. However, there are 5 paid supervisors who provide administrative and other support to doctors. In addition, there many volunteers. The church employs only Christian staff. The majority of doctors belong to the church.

### *Staff payment*

Some doctors work at the clinic on a voluntary basis, others are paid. The clinic would not disclose the numbers of paid and volunteer staff. Those that are paid, are paid on the basis of the number of patients they see. Doctors receive 40% of the consultation fee, or LE 1.60 for every patient treated. The dentist receives 40% of the total patient bill.

The potential for a doctor to earn in this clinic is not very great. The number of patients a doctor sees in a day/session varies considerably depending on the season. Sometimes they may see no patients, and at other times they may have up to 10. Some, such as the cardiologist see as few as 2 to 3 patients per session. She works only 2 sessions a week, and therefore if paid would earn about LE 40 a month.

### *Staff motivation and turnover*

"The sole aim is to serve", and "are able to combine service with work" were amongst the main reasons given by doctors for working in the church clinic. Money appears to be a less important motivating factor in this clinic, since the potential to earn is fairly low. The younger doctors also cited work experience as a reason for them to work there. Undoubtedly however, "serving the poor" is the main motive of doctors working in this clinic.

Doctors seem to gain considerable personal satisfaction from working in the clinic, but they appear to be professionally satisfied as well. For example, the dentist who works part-time in a government hospital, said that church dental surgery is better equipped than his government surgery.

Most doctors stay at the clinic for 1 and 2 years. However, many leave to work abroad.

### ***Health Service Provision:***

The St George church provides only outpatient health care. A polyclinic provides outpatient consultation in 12 medical specialties, one for each of the 12 consultation rooms. Specialties include, paediatrics, medical surgery, urology, neurology, dermatology, ENT, obstetrics and gynecology, orthopaedics, opthamology, physiology, and dentistry.

The polyclinic provides largely curative care. However, once a week the clinic director runs health education classes in the church. These are provided as part of a regular meeting that takes place in the church every Monday evening. Monday is the day set aside by the clinic for treatment of poor patients. Health education is provided for about 10 minutes in this meeting. Topics covered include family planning, female circumcision, child weaning, immunization, AIDS, and smoking and drug addiction. Although preventive and promotive aspects of health care are a stated objective of the society, in practice they comprise a limited part of their efforts.

Antenatal care is provided by the OB/GYN specialist. She refers pregnant women



for delivery to either a government facility or another church society that has an inpatient facility. Immunization services are not provided.

Cases they are unable to treat are referred to another doctor, usually a private practitioner. If the patient is poor the doctor will not charge. The church has a network of private doctors who are willing to provide their services free of cost to the poor. The church may reimburse them for the cost of diagnostic investigations. If the patient needs to be hospitalized, doctors frequently refer the patient to the public facility in which they work. The polyclinic also refers some cases to the nearby CCO hospital. This is mostly for casualty cases. If required doctors make home visits.

The clinic is open 7 days a week, between 11:00 and 1:00 during the day, and from 7:00 to 10:00 in the evening. Monday evenings are especially for treatment of the poor.

There is no appointment system at the clinic. They did attempt giving patients prior appointments, but it was not successful. Patients usually just turn up and wait in turn to see an appropriate specialist. On arrival they are required to register with a supervisor. They are given a slip of paper on which is written the specialist they are to see and the fee that they have paid. Free patients are given a white ticket. Doctors are paid on the basis of this ticket.

The clinic maintains no records of outpatients. Treatment is on a purely episodic basis. The clinic does not even monitor the number of patients seen by the different specialists. However, they do keep a monthly record of the number of patients provided free and subsidized care.

### *Diagnostic facilities*

A small laboratory was recently opened in the clinic. This undertakes basic routine laboratory tests. They have an ultrasound machine, and an ECG. There is no x-ray facility. However, the clinic have an arrangement with a nearby private x-ray facility. On the request of the clinic director the x-ray may be provided free of cost. The clinic reimburses the cost of x-rays for poor patients.

### *Pharmacy*

The clinic does not have a pharmacy on the premises. Patients are given prescriptions and have to purchase drugs from an outside pharmacy. However, the clinic does keep a small stock of drugs for poor patients. These are composed largely of the samples given to doctors by pharmaceutical companies, and donations from the general public. In addition, the clinic buys a basic stock of drugs for the Monday evening clinic. In circumstances when a

drug is not in stock for a non-affording patient, they have a special arrangement with an outside pharmacy who provides drugs at a specified discount or entirely free. The clinic then reimburses the pharmacy at the end of each month.

The clinic suffers from an acute shortage of space. There is no potential to extend the clinic to provide further diagnostic or pharmaceutical facilities. The church hopes to open an inpatient facility in the future, but this will have to be located elsewhere.

### *Quality of care*

The clinic is exceptionally clean and well-maintained. The equipment is in good working order. The facility appears to provide a very high quality of care. One of the doctors said that he brings his own family to the clinic when they are sick. One person noted that it looked like a private practice.

The clinic director questioned the appropriateness of the polyclinic model of providing health care. He felt that probably 95% of health problems could be dealt by a general practitioner. On the other hand he said Egyptians have a high awareness of the different medical specialties, and demand that level of care.

### *Charging for services*

Outpatients are charged on a fee for service basis. For example, they pay LE 4.00 for a consultation with a specialist. This includes one free follow-up visit. LE 25 for an ultrasound and LE 7 for an ECG. Dental patients are charged LE 3.00 for a initial consultation. They pay for each additional service received, eg a filling costs LE 15.

On Monday evening an outpatient consultation costs LE 1. This is the day set aside for treatment of the poor.

### Exemption of the poor

The clinic reduces or waives completely charges for non-affording patients. Monday evening is devoted to treatment of the poor. On this day consultation costs LE 1 and drugs are provided free. The clinic originally provided services free of cost on this day, however they found that many patients abused the service, wasting both the doctors time and drugs provided. The LE 1 charge has succeeded to discourage this behavior. Charges for diagnostic tests are also waived.

On other days, apart from Monday, the supervisor at the registration desk has the discretion to decide who should receive subsidized care (i.e. pay LE 1).

However, totally free patients have to seek permission of the polyclinic director. He asks patients questions regarding their economic situation. Poor patients are also provided with free drugs. The clinic director feels that it is not a difficult task to decide who should be entitled to subsidized or free care.

On average, about 600 patients receive subsidized or free care in a month.

### Fee setting

The main criteria for setting fee levels is the cost of the service. The polyclinic director and doctors together estimate the approximate cost of the service. Consideration is also taken of the ability of patients to pay. The final decision on fees is taken by the church committee.

When the clinic opened 5 years ago it charged LE 3.00 for a consultation. Over this period, the fee has increased only by LE 1.00.

### ***Health Service Utilization:***

The clinic does not keep a record of the number of patient contacts. It would have been possible to estimate the number by examining outpatient tickets. However, the church did not allow access to this information. As a result it was not possible to determine exactly how many people use the facility. The clinic director estimates that between 400 to 500 patients visit the clinic a week. They do, however, maintain a record of the number of patients who receive free or subsidized care. Approximately 600 patients a month, or almost 30% of all patients, get subsidized and free care.

### *Patient interviews*

The interviews indicate (see Annex 1 for a selection of interview transcripts) that patients perceive the quality of care to be very high and prices to be very affordable. The "treatment provided is excellent", "the doctor gives his attention and explains things", "they provide good follow-up", were some of the patient responses to questions regarding the quality of care. None of the patients complained of having to wait a long time to see the doctor. Although one woman said that she had waited one hour. The average waiting time was 20 minutes. All patients felt that the charges were accessible to the majority of people.

The clinic appears to attract all income groups from the indigent to the well-off. No free patients were interviewed. However, interviews were not conducted on Monday, the day for non-affording patients. Although the clinic does appear to attract patients of all classes it is the middle and low- income groups who are the main users. Occupations of those interviewed included, student, retired

accountant, nursery supervisor, and a civil servant. One patient's husband was a diplomat. A couple of those interviewed were car owners.

Amongst the reasons given for using the facility were quality and convenience. The majority of patients live close to the clinic. One woman walked to the facility and it took her 14 minutes. The furthest travel time was one hour by taxi. However, this woman lived in the locality before she married and chooses to continue to come to the church clinic. Some of the patients had previously used the for-profit private health sector. The main reason for switching providers is not price but quality. They feel that the service provided by the church clinic is superior to the private sector. Two patients had used other church and mosque clinics. Again they feel that the St. George clinic provides a better service. One woman works in the Ministry of Agriculture, and is covered by health insurance. She chooses not to use HIO facility since they are "too slow" and "difficult to deal with".

Although none of the patients explicitly mentioned price as a reason for using the facility, it is likely to be a contributory factor. Prices are extremely nominal in comparison to the private sector.

Clients had heard about the clinic from friends and relatives, and from being associated with the church.

All the patients interviewed were Christians, but the facility does appear to get some Muslim clients.

### ***Costs and Financing:***

The church did not permit information to be given on the costs and financing of the polyclinic. Some information on the financial status of the facility was gleaned during interviews with the clinical director.

#### ***Sources of Income***

The clinic has two sources of income, fees and church donations. Fee charges have already been explained in some detail above. Donations represent those funds given directly by individuals to the church.

#### ***Costs***

The only information given on clinic costs were those of drugs. The clinic spends approximately LE 1600 per month on drugs for non-affording patients. Including

the value of the sample and donated drugs, drug costs amount to LE 5,000 per month.

*Financial status (revenue to cost)*

The fee revenue is not sufficient to cover all recurrent costs. It is used towards the salaries of doctors and supervisors, and the cost of laboratory and dental kits. Other recurrent costs, such as drugs, electricity and water, telephone and maintenance are met by church funds. Donations also finance all capital expenditures, such as construction and equipment.

### **3. Gammeya El-Fath Clinic**

#### ***Background:***

The clinic occupies a building attached to the El-Fath mosque. The Gammeya El-Fath clinic is located in a quiet, green, residential area of Heliopolis, but still close to a main road. This is a fairly affluent part of Heliopolis. The clinic is about 15 minutes walking distance from the CCO-run Heliopolis Hospital.

Four mosques in the Heliopolis area, of which El-Fath mosque was one, came together in 1966 and registered a society. The society first contemplated providing health services in the mid '80s. They felt that the worsening economic situation in the country was causing people to experience considerable difficulties in obtaining good quality, affordable medical care. It was in response to this felt need that the society began planning for a hospital and polyclinic.

The society began raising funds for the construction of the health facility in 1988. The outpatient clinic was opened in 1991 on completion of the ground floor. Fund raising and construction of the inpatient facility continued into the early '90s. The hospital was completed in 1993, but inpatient services have not yet started since the society are still awaiting a license to be granted from the MOH.

The society provides many other social services. These are spread over the 4 mosque sites. They include, 2 halls for social events, an English language school, a nursery, vocational training for the handicapped, a social and cultural centre, and an old people's club.

#### ***Organizational Structure and Management:***

As mentioned, the society represents 4 mosques in Heliopolis area. Health services are provided at one of these - the El-Fath mosque. The administrative offices of the society are located at the El-Fath mosque site, on the fourth floor of the hospital and clinic building.

The society comprises 15 elected members. The health facility is directly managed by a hospital board. Board members include some society members and the hospital director. The hospital director advises on technical matters related to the hospital and clinic. Although currently he is also responsible for the day-to-day management of the clinic. They plan to hire a separate hospital administrator once the hospital starts operating.

At present the fee revenue from the clinic goes directly to the society. After the hospital is running they plan to open a separate bank account for health services.

### *Staff*

The society employs 15 specialist doctors and 15 consultants. The consultants are a recent addition. They were hired by the hospital director when he took up his post 6 months ago. The hospital director is a professor at a university medical school, and most of the consultants are his university colleagues. The director works at the clinic 3 evenings a week. Most of the specialists work between 2 and 3 evenings a week. It is likely that the consultants joined because of the imminent opening of the hospital.

All the doctors are employed elsewhere, either in government, university, or private hospitals. In addition some of the doctors have their own private practice, or work in another mosque facility. For example, the internal medicine specialist has been working at the clinic for 3 years. He now attends 2 evenings a week but when he first joined as a newly qualified doctor he worked at the clinic 3 to 4 times a week. He presently holds posts at the university teaching hospital, and Nassar International, a private hospital. At one time he worked at two mosque clinics simultaneously.

The clinic employs only Muslim doctors.

### *Staff payment*

Doctors are paid on the basis of the number of patients they see. They receive 40% of the consultation fee. A specialist earns LE 1.60 for each patient treated, and a consultant earns LE 4. Some of the doctors work on a voluntary basis. However, it is not possible to determine the exact number of doctors who work voluntarily since they choose to remain anonymous.

On an average a doctor sees about 4 to 5 outpatients each evening. This means that if they work just 2 evenings a week they earn about LE 64 a month, while a consultant attending once a week and seeing the same number of patients earns about LE 80. This compares to a government salary of LE 150 for specialists. Therefore, El Fath doctors are able to supplement their government salaries by over half.

El-Fath society plans to pay surgeons 40% of the total operating cost, and the anaesthetist 20% of cost.

### *Staff motivation and turnover*

One doctor working at the clinic put his motivation for working in the clinic succinctly as "working here is spiritual more than material." Clearly, the scope for doctors to earn in this clinic is limited by the fact that there are few patients.

Therefore, it is likely that non-financial factors such as public and religious service are more important. Fifteen consultants joined the clinic six months ago in anticipation of the hospital opening. The scope for doctors to earn will be greater once inpatient services start.

A young doctor who started working in the clinic soon after qualifying said that it had provided him with his first work opportunity outside of the teaching hospital which was valuable experience.

At present, the clinic has a fairly high turnover of doctors. However, the hospital director thinks this will be less because, once the hospital opens, there will be more patients and doctors will be professionally more satisfied.

### ***Health Service Provision:***

The society currently runs a polyclinic which provides outpatient care. They are soon to open a 62-bed hospital. The health facility is located in a 4 story building attached to the mosque. The clinic occupies the ground floor, the hospital 2 floors, and the society's administrative offices on the top floor. The clinic and hospital are described in turn.

#### ***Polyclinic***

The clinic comprises 6 consultation rooms. Outpatient consultation is available in a number of specialties. This includes, physiotherapy, ophthalmology, internal medicine, ENT, surgery, gynecology, dentistry and dermatology. The services are entirely curative. As in the other mosque clinics, some preventive and promotive care is provided by the gynecologist.

The polyclinic is open only in the evenings with the exception of the dental surgery. In the summer the clinic opens between 8:00-10:30, and during the winter between 6:00 to 10:30, six days a week. The doctors also make home visits.

There are no patient records. Treatment is on an episodic basis. Although some of the specialists, e.g. physiotherapy and dentist, do give the patient a medical card. However, this acts more like an appointment card, and contains minimal health information. The hospital director hopes to introduce a computerized record system so that returning patients will have a medical record on file. The clinic maintains an OPD register. This records the date, name of patient, address, specialist to see, etc.

The clinic is clean and attractive. There is adequate waiting area. The equipment is in good working order and appears to be well-maintained.



### *Hospital*

The society is awaiting a license from the MOH to open a 62-bed hospital. The MOH turned down the first application on the grounds that certain equipments and facilities were not available. A license has however been granted by the Medical Syndicate. The hospital will have 3 operating theaters. The operating theaters and other hospital departments are not fully equipped yet. They are attempting to raise funds to purchase a sterilization unit, a sonar, an x-ray machine, laundry machines and physiotherapy equipment.

They have a number of private wards. These are air-conditioned and they plan to purchase television sets for each private room. The hospital does not plan to provide food to inpatients.

### *Diagnostic facilities*

The society does not possess an x-ray facility. They are currently trying to raise funds to purchase an x-ray machine. This will be a vital piece of equipment for the hospital. Indeed the lack of an x-ray may have been one of the reasons why MOH has refused to grant them a license. For the moment they have an arrangement with a private facility in area. There is a laboratory on the premises which is capable of undertaking simple tests. More complicated tests are sent outside to a private laboratory. The society is planning to buy other diagnostic equipment to support inpatient services. This includes an ultrasound, and endoscopic laparoscope. They would also like to purchase a CT scan.

### *Pharmacy*

There is a pharmacy on the mosque premises. However, it is not run directly by the society. They have rented out the space to a private individual. The society has no direct influence over the pharmacy, e.g. over drug prices. Individual doctors do consult with the pharmacy regarding the types of drugs stocked. The pharmacy has been there for 8 years, well before the society started providing health services. The hospital director said that they would like to open a pharmacy within the hospital once it starts operating so that they can provide drugs at a discount.

### *Charging for services*

There is a differential charge for an outpatient consultation with a specialist doctor and a consultant, LE 4.00 and LE 10.00 respectively. The charge includes one follow up visit within a one-week period. The patients decide who they would like to see. But it also depends on the availability of a particular specialty on a given day.

Charges are levied for all diagnostic tests. For example, a urine test costs LE 12, a stool examination LE 4, etc. A charge of LE 10 is made for a home visit in the locality, and LE 15 for further away. The hospital director said it was wealthier clients who tended to ask for home visits.

The hospital plans to charge inpatients a fixed amount depending on the complexity of the operation performed. The charge will include bed stay, but exclude diagnostic investigations and drugs. Operations have been classified according to whether they are simple, small, medium, big or serious. Patients in the private ward will be charged an additional daily bed fee.

### *Exemption of the poor*

The society have a central fund from which they support the health costs of non-affording patients. Permission has to be sought either from the hospital director or a society member. They do not record the number of outpatients provided free care, but it is sizable. The director estimates the number to be about 200 a month. However, apparently this includes those patients referred by other mosque societies. It is uncertain whether this figure represents only patients that are truly non-affording or also includes those persons referred by other societies as "special" favors.

Poor patients may also be given free x-ray services. As mentioned, the society has an arrangement with a private x-ray facility. On the instruction of the society they may waive the fee. The society reimburses the clinic at the end of each month. It was not possible to quantify the volume of free care given. Doctors also provide sample drugs to poor patients given by pharmaceutical companies.

### *Fee setting*

Outpatient fees are more or less arbitrarily set. They may take into consideration charges made by other mosque clinics in the vicinity. The inpatient fees are based on a rough estimation of the doctors time, the bed stay, and cost of supplies. These inputs and their cost were jointly decided by the doctors.

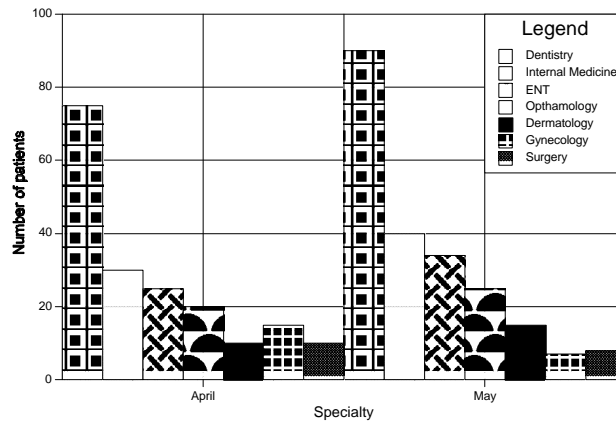
### ***Health Service Utilization:***

The majority of outpatients come from the locality. Despite the fact that the clinic is located in a fairly affluent area, most of the patients are of low and middle income. They include porters, watchmen and shop owners. The society hopes that once the inpatient services start, patients will be attracted from further afield.

Table 5 shows the actual number of outpatient contacts according to different specialties in April and May, 1994.

**Table 5**

**Outpatient contacts April/May 1994**



These figures indicate very low utilization of the polyclinic. On an average the clinic sees only 200 patients a month. However, those patients receiving free care are not recorded by the clinic. Free patients are estimated to number about 200 a month. This doubles the utilization rate, but overall it is still fairly low. Doctors attribute the low number of service users to the presence of many other mosque clinics in the vicinity. They anticipate that the number of patients will increase once the hospital starts providing services. However, given the low uptake of clinic services, the appropriateness of opening a 62-hospital is seriously questioned.

*Patient interviews*

Clinic interviews are fully transcribed in Annex 1. They indicate that patients are extremely satisfied with the quality of care provided and the fees charged. Doctors are "excellent", "friendly" and "trustworthy". The clinic is clean and fees are affordable. They did not have to wait long to see the doctor. The longest a patient waited was 30 minutes.

Some of those interviewed previously went to other providers before discovering the mosque facility, such as the CCO hospital and government hospital. In comparison, they find the mosque clinic services cleaner, cheaper and of better quality. One patient said that there was no comparison between the government hospital he was using and the mosque clinic.

Patients had either heard about the clinic from friends or by virtue of living close

to the facility. The patient closest to the clinic lives 3 minutes walking distance, and the furthest traveled one hour by bus to reach the clinic. However, the majority came from the locality.

Most of the patients interviewed are from the middle to low-income. They include the son of a taxi driver, a butcher, a courier, and a teacher. The teacher was a car owner.

### ***Costs and Financing:***

This section examines the costs and financing of the polyclinic. Expenditure thus far incurred on construction and equipment of the hospital is also estimated.

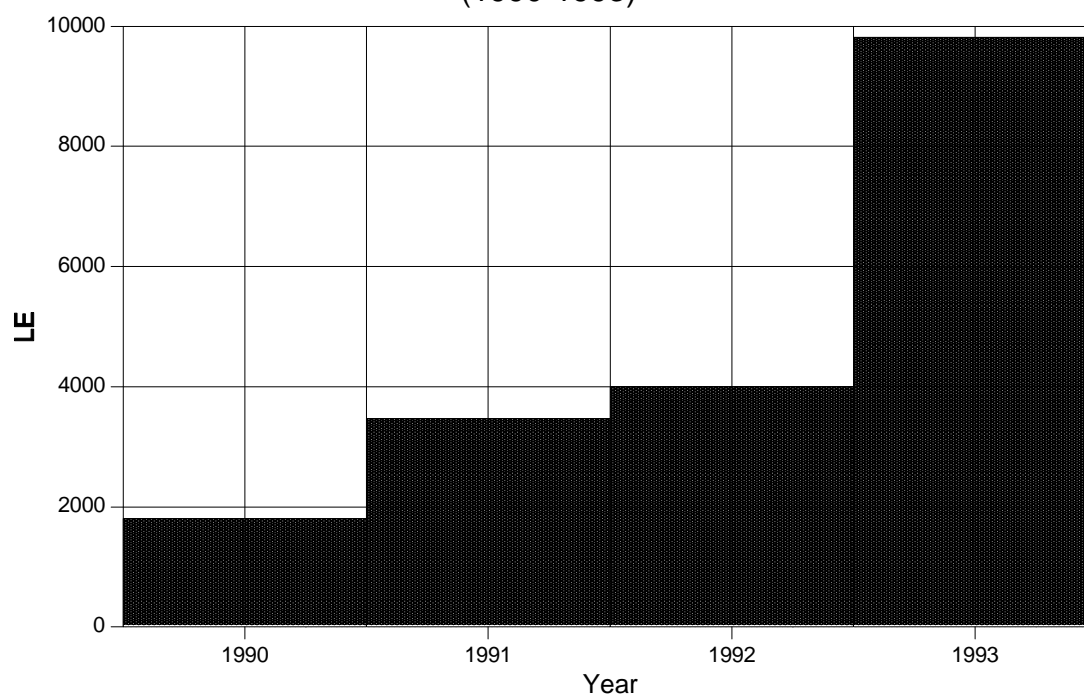
### ***Sources of Income***

Table 6 examines the trend in clinic fee income over the last 4 years. The revenue generated from charges has been steadily increasing over the years. It increased from LE 1801 in 1990 to LE 9818 in 1993. This is due to an increasing number of patients.

**Table 6**

## Fee Income

(1990-1993)



Of the total LE 9,818 fee income in 1994, LE 1061 came from small operations conducted in the hospital.

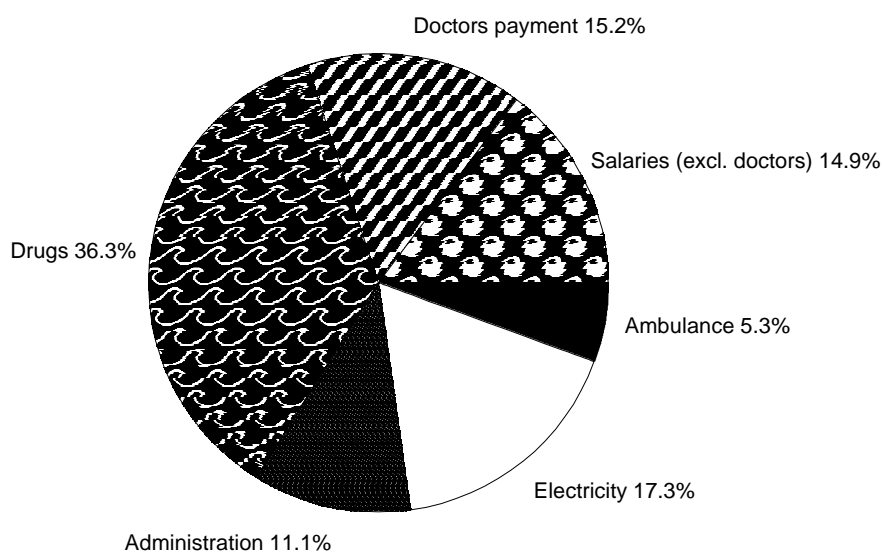
## Costs

Table 7 gives a breakdown of clinic expenditure in 1993.

**Table 7**

**Clinic Expenditure**

(1993)



The polyclinic has very low running costs. Surprisingly, drugs represent the largest cost item, at 36% of total cost. The society do not provide drugs directly, however this may represent the cost of free drugs provided to poor patients. Salaries including the payment to doctors account for 30% of total expenditure. Other cost items represent substantially less.

### *Financial status (revenue to cost)*

Total polyclinic income totaled LE 9818 in 1993. In the same year expenditures totaled LE 14,121. This results in a deficit of LE 4303. This deficit was met by

donations made to the society.

Table 8 shows the consolidated income and expenses for the society in 1993 for all activities.

**Table 8**

**Consolidated Income and Expenses of Society for 1993**

Balance beginning	LE 947,805
Total income during year	LE 452,896
Total expenditure	LE 409,710

This means that overall the society had a surplus of LE 910,991. In comparison, clinic expenditures represent a very small proportion of total society spending. A large amount of the above went towards construction and equipment for the hospital.



#### **4. Emad El Dean Medical Centre, Downtown Cairo**

##### ***Background***

This study came to an abrupt stop after one week. The chairman of the society withdrew his cooperation saying they had changed their mind about their involvement in the study. Preliminary information gathered on this society is presented below.

The Emad El-Dean health facility is attached to the Emad El-Dean mosque. The mosque is located in downtown Cairo. The area is both commercial and residential.

The mosque has a registered society comprising 15 elected members. The society began providing health services in 1985. Health is one of the many other social services provided by the clinic including, a nursery school, adult literacy classes, financial assistance to the poor, religious pilgrimage to Mecca, and religious education classes. The society meets once a month.

A manager is responsible for the day-to-day running of the health facility. He is assisted by a hospital administrator and an outpatient administrator.

##### ***Health Provision:***

The society runs a polyclinic and an 8-bed hospital. The hospital is presently not functioning. It is used only for emergency cases, for example, deliveries. The society plans to expand the hospital to 40 beds.

The polyclinic comprises 7 consultation rooms. Outpatient consultation is available in a number of medical specialties including dentistry.

Of all the four clinics studied this was the least pleasant in appearance. The building was dark and dingy. It was nevertheless fairly clean.

The clinic is open from 12:00 to 3:00 in the afternoon, and 7:00 to 11:00 at night.

The health facility does not have a x-ray machine, or pharmacy. They have a special arrangement with an outside x-ray facility which gives them services at a discount. There is a small laboratory in the hospital.

Forty doctors currently work in the clinic. Most work between 2 to 3 days/sessions a week. But a few work as much as 6 days a week. All have other jobs in private and/or government health sectors. One doctor works in the MOH. Very few of the doctors have their own private practice. The society

employs only Muslim doctors.

Doctors pay is related to the number of patients they see. They receive 50% of the consultation fee. Surgeons also get 50% of total inpatient costs.

The society levies a LE 2 consultation fee. Dental charges depend on services given. There are fixed charges for inpatient care. These relate to the severity of the procedure performed, and include operation costs and bed stay.

Poor patients are exempted from charges. The volume of subsidy given each month is not known. Inpatients are permitted to pay in installments.

Between 100 to 200 patients visit the polyclinic each day. The majority come from the locality. The chairman said that the clinic attracts all income groups. He felt that it was the reputation of the particular doctor that was the main reason for visiting the facility.

The society has two main sources of income, fee revenue and donations. Fee revenue generated is sufficient to cover operating costs of the health facility. The account indicated that the polyclinic subsidizes the hospital. Donations are used to meet equipment and other capital costs.

## **SUMMARY AND CONCLUSIONS**

Health services are provided by all four religious bodies through an independent registered society. Health is just one of the community services provided by the societies.

The rationale for starting health services was almost the same in all societies. Services were started against a background of increasing health care costs in the private sector, and poor quality public services unable to meet all health needs. Services were set up largely to bridge the gap between these two sectors - to provide high quality services at low cost, mainly to the low income population. An additional objective of the St. George Church clinic is to provide work opportunities and experience to doctors. All health service start up costs were supported by donations, e.g. facility construction, and equipment.

The types of health services provided by the religious societies were also similar. Only one society, Medan El-Gamee provides inpatient care. They run a 30-bed hospital. Gammeya El-Fath is about to open a 62-bed hospital. All societies provide outpatient care through "polyclinics". Polyclinics offer services in a multitude of medical specialties. The appropriateness of this degree of specialization at the first tier of health contact can be seriously questioned. The director of the St. George clinic felt that 95% of the health problems they see could be dealt with by a general practitioner. Moreover, the polyclinics provide very limited preventive and promotive health inputs. Only the St. George clinic provides formal sessions of health education.

The facilities possess varied diagnostic capacity. Aphgany has an x-ray facility, a laboratory, an ultrasound and other diagnostic equipment, while those societies running only polyclinics do not have an x-ray machine. They have made arrangements with private x-ray facilities in the area, and in some cases get a discount. They do have laboratories however, where they are able to conduct basic investigations. On the whole, it can be said that the mosque and church clinics studied are generally well-equipped for the type of service they provide. They do not possess overly sophisticated or specialized equipment, although the hospitals do aspire towards acquiring MRI machines and CT scans.

Two of the societies have a pharmacy on the premises. In both cases they are not run directly by the society but are contracted out to private individuals. The pharmacies pay rent for the space. Aphgany's arrangement is innovative from the point that services are contracted on the condition that drug prices be 5% cheaper than the commercial sector. In the other two clinics, patients purchase drugs from outside pharmacies. All clinics keep a small stock of drugs

comprising of samples from pharmaceutical companies which they provide free to non-affording patients.

All the doctors employed at religious health facilities also work in other sectors. For example, almost all doctors have a job in the public sector. The MOH guarantees employment to all doctors. In addition, they may work in private hospitals and/or have their own private practices. Some doctors work in two mosque or church clinics at the same time. The societies do not object to doctors who work in their facilities having a private practice. Deflection of patients by the doctors to their private practice does not appear to be problem.

The doctors who work in the clinics range from newly qualified doctors, to specialists and consultants, including university staff. Mosque societies only employ Muslim doctors, while church societies only employ Christian doctors. Doctors are paid on the basis of the number of patients they see. Typically they receive 40% of the consultation fee. Surgeons also get a fixed proportion of inpatient costs. This includes the cost of operation and bed stay.

Their motivation for working in the clinics includes community and religious service, income and work experience. Ability to serve the poor is the main reason given by doctors for working in these facilities. In fact, some doctors provide their services on a voluntary basis. It was not possible to determine the extent of voluntary service since they wished to remain anonymous. There is a strong commitment to community service both amongst Muslims and Christians. Since doctors are paid on the basis of the number of patients they see, in polyclinics such as Aphgany which has high utilization, their income can be considerable. Given the fact that government salaries are so poor, earnings at religious facilities can serve as a substantial supplement. In the other clinics where the number of patient contacts are not so high their potential to earn is more limited. Gaining work experience and establishing a name are the other given reasons. Working in these facilities does appear to facilitate their setting up a private practice. Doctors appear to be professionally satisfied at mosque and church facilities.

The monitoring and management capacity of societies is very weak. Health facilities keep few records and maintain few registers. For example, no records are kept on outpatients. As a result treatment is episodic in nature. Planning is undertaken on an ad-hoc basis and not on basis of need. For example, El-Fath mosque are ready to open a 62-bed hospital when their polyclinic sees only about 400 patients a month.

The health facilities charge on a fee for service basis. For example, charges are levied for a consultation, diagnostic test, operation, etc. Fee levels are nominal. Consultation fees ranged from LE 2 to LE 4 in the clinics studied. El-Fath mosque

clinic charges LE 10 for a consultation with a senior consultant. All provide exemptions to non-affording patients. St. George polyclinic sets aside a special day each week exclusively for the poor. Aphgany has special subsidy committee that administers a fund for the poor. The volume of subsidy provided varies. In Aphgany it represents only 0.6% of total patient income, while at St. George clinic almost 30% of patients receive free or subsidized care. The societies do not seem to experience any difficulties in deciding who should get subsidies. They say that means testing is a fairly easy exercise. Some of the patients are also known to the society.

Utilization of the health facilities varies considerably. For example, Aphgany polyclinic sees about 500 patients every day, while El-Fath sees only 400 patients a month. On the other hand, the Aphgany hospital has an occupancy rate of less than 50%. The majority of patients live close to the facility.

All patients had a very high perception of the quality of care provided and there was considerable patient satisfaction. There were universal positive responses to questions of staff competence and politeness, clinic opening times, cleanliness, waiting times, etc. The late night schedules in particular are extremely convenient for people who work during the day. Fees were thought to be affordable.

Patients preferred the mosque/church facilities to the government and CCO-run hospitals. Amongst the reasons for using the facilities were price, convenience and quality. However, one Aphgany outpatient said that if she needed inpatient care she would go to a private hospital. It is strange that patients prefer the doctors in religious facilities and are more satisfied with the treatment received, when very often the same doctors serve in the public facilities.

The health facilities attracted patients of all income classes. However, the bulk of patients were from low/middle to low-income classes. They included, a taxi driver, a butcher, courier, a teacher, government civil servants, and a diplomat. Muslims predominately use mosque health facilities and Christians predominately use church facilities.

Mosque and church clinics have two main sources of income, service users and donations. Mosques tap a further source through zakat contributions, although in Aphgany, the hospital and clinic are providing funds to the zakat committee. This is in lieu of rent. Fund raising is not undertaken in an organized manner. It is more dependent on the personal contacts of society members.

It was not possible to undertake a cost analysis of the facilities. However, services appear to be provided at low cost. Especially at Aphgany where utilization is very high and costs fairly low. Another factor that keeps cost down

is the system of doctor payment. Doctors are paid on the basis of the number of patients they treat.

The financial status of health facilities differ. At most, fee revenue is adequate to cover only recurrent costs as is the case in Aphgany. In St. George and El-Fath, fee revenue generated is not sufficient to meet all recurrent expenditures. Donations meet the deficit in recurrent expenditure in these clinics. There is no problem in meeting doctors salaries since their payment is linked to the number of patients. In all clinics, donations meet capital costs such as construction, vehicles and equipment. At Aphgany it seems that outpatient services cross subsidize inpatient costs.

The case studies indicate that religious organizations play an important role in the health sector in Cairo. They make a significant contribution to meeting health needs in the city. Some of their strengths include tapping additional resources for the health sector, their ability to reach low income population, provision of accessible, low cost quality services, client and doctor satisfaction. Moreover, they are locally-based, locally-run autonomous organizations. They successfully bridge the gap between high cost private health services and low quality government services.

However, the sector suffers a number of weaknesses. These include overspecialization for first level of care, lack of preventive and promotive health inputs, poor monitoring and record keeping, no continuity of care, ad hoc planning and the non-secular nature of health utilization and staff employment.

Great potential exists to strengthen the capacity of religious organizations to provide preventive and promotive health activities, e.g., antenatal care, family planning services, and screening for certain diseases.

It is difficult to conclude the impact of the religious health sector on other providers. There were reports of some private practices having closed down in the vicinity of religious facilities. If any, the religious sector has probably displaced some private sector use by the middle class. The sector most certainly lessens the burden on public services.

The desirability and feasibility for replication this model of health provision is difficult to judge. The strengths and weaknesses of the sector have been discussed at length. The organizations are extremely popular and appeal to a wide section of the Cairo population. One observer felt the sector has almost reached saturation in Cairo. However there exists considerable potential for replicating this experience to other urban settings in Egypt. Religious motivation is a strong feature of this model of health care provision. And it is such imponderables that make replication a difficult task. Nevertheless, the sector

holds many lessons for other such private initiatives in health.

This study was not able to address all the issues outlined in the original scope of work because of the lack of cooperation and reticence of religious societies in providing information. For example, it was not possible to assess the efficiency of health service provision. Further research in these areas, ideally by a local organization would yield further valuable information.

## **ANNEX 1**

### **SELECTED CASE STUDIES OF PATIENT INTERVIEWS**

#### **A. AL APHGANY HOSPITAL, HELIOPOLIS**

Interviews were conducted over two separate days.

##### **PATIENT 1**

Patient 1 is female, aged 23 years, and (unveiled) Muslim. She has a university degree but is currently not working. Her father is a retired director of a public sector company. There are 8 household members in her family.

Both she and other members of her family are frequent visitors to the clinic. Today she had a consultation with the orthopaedic surgeon regarding her knee. She was asked to come back the next day for a x-ray. She waited 15 minutes to see the doctor.

She said that she uses this facility for outpatient care, but goes to a private hospital for inpatient care. Although she mentioned that her niece was admitted to this mosque clinic for a tonsillectomy. She also said that there was a huge difference in cost between a private practitioner and this facility. It would cost at least 50 pounds for a consultation with a private specialist. The mosque clinic is very convenient for her since it only takes her 3 minutes to walk to the clinic from her home.

She said that she does not avail of the other mosque society services, only the health service.

##### **PATIENT 2**

Patient 2 is female, 54 years old and a widow, (Muslim and veiled). This is her fourth visit to the clinic. Previous to this she was visiting a private practitioner. However, she was unhappy with the treatment given by him. She prefers the treatment she receives from this clinic. She said that the doctor takes more care here and gives her more attention.

She used to pay 20 pounds for a consultation with the private practitioner, compared to only 3 pounds here. Therefore she also prefers this clinic on cost grounds.

Her son works as a calligrapher in the neighborhood and told her about the clinic. She came to the clinic by taxi and it took her 15 minutes to reach. She had an appointment and therefore did not have to wait to see the doctor. Her household comprises 4 members.



### PATIENT 3

Patient 3 is female, 21 years old, unmarried (Muslim and unveiled). She is a student and is studying for her university degree.

She has been coming to the clinic for the last 8 years. She uses no other provider. Today she saw the dentist. She had come with an appointment and therefore did not have to wait to see the dentist.

She thinks that the fees are very affordable to almost everyone. She knows that in the private sector it is much more expensive. She finds this clinic both convenient (she lives 10 minutes walking distance from the facility) and good quality.

Her father is in the army. There are 7 household members.

### PATIENT 4

Patient 4 is female, aged 26 years. She is pregnant and had come today for a ultrasound. This is her second visit to the clinic. Previously she was using another much smaller mosque clinic. Her relatives had told her of the existence of this clinic, and that it was much bigger and better than the one she was using.

This is her first pregnancy and she plans to deliver in the hospital. She waited 15 minutes to see the doctor. She is happy with the treatment she receives - the doctor takes his time, the fees are affordable. She paid 11 pounds for a consultation and ultrasound. She was given a prescription but plans to purchase the drugs later at an outside pharmacy as she is not carrying sufficient money to buy them at the clinic pharmacy.

She has been told by the doctor to visit twice a month. She came by bus and it took her half an hour to reach the clinic. She does not work. Her husband has a fruit shop. They live alone.

### PATIENT 5

Patient 5 is female, 24 years old, unmarried, university graduate who is not working (Muslim, veiled).

She has been using this clinic for the last 2 to 3 years. Before this she was going to a private practitioner. However she prefers the services at this clinic. The doctor takes more time and care, and also listens to her. She said that although there is a significant cost difference between this clinic and the private sector, it was a less important factor in choice of facility. More important was the quality of care provided and the behavior of the doctor.

Today she had a consultation with the dermatologist. He gave her a prescription but she does not plan to buy the drugs at the clinic pharmacy. Her uncle has his own pharmacy and she will get the drugs there. She did not have to wait to see the doctor.

Her father works for the government customs department. There are three members in her household.

She walked to the clinic and it took her 30 minutes. She heard about the clinic from friends who also use the clinic. Her mother had an operation at the clinic fairly recently.

#### PATIENT 6

Patient 6 is male, 30 years old, married with no children. He and his wife live alone. This is his first visit to the clinic. He works in the area and heard about the clinic from his work colleagues.

He usually goes to a private practitioner but chose to come here because it was convenient and fit in with his work schedule. He has a degree in social work and works as an administrator in a cinema hall.

He came straight from his work and it took him 3 minutes to walk. He waited 45 minutes to see the ENT specialist. He was unhappy that he had to wait so long but otherwise was satisfied with the treatment given by the doctor. He felt the service was extremely cheap and good value. He pays LE 10 pounds for a consultation with the private doctor. He would wait and see if the treatment was effective and if it was, would return to the clinic for future health problems. He had been given a prescription but was undecided whether he would purchase the drugs at the clinic pharmacy.

#### PATIENT 7

Patient 7 is male, and aged about 45 years. He has an amputated leg and looks visibly poor and destitute. He does not have regular work.

He lives in the area and said he always comes to the clinic for any health problems. He is known to the mosque society and receives free care. Today he came because his son has an abscess. He thinks that as such the treatment is not expensive for the majority of people but for him it is still difficult to pay. (free drugs?). He waited 15 minutes to see the doctor.

#### PATIENT 8

Patient 8 is female, aged 32 years, married with one daughter. (Muslim and veiled). She started using the clinic four years ago after the birth of her daughter.

She brings her daughter here for health care but uses the health insurance hospital herself. She works in the Ministry of Social Affairs and is therefore covered by health insurance. The insurance does not cover her husband or any dependents. As a result, her daughter and husband use this mosque clinic.

Today she saw the pediatrician as a result of an allergy that her daughter has. She said that because she works in the MOSA she is entitled to receive services at half price (she has an ID card which she showed to the outpatient registrar). She paid LE 1.50 for the first consultation and LE 0.50 for the follow-up contact.

She thinks the treatment is very good, she likes the doctor and feels the fees are very convenient. She waited 10 minutes to see the doctor. She said that if needed for her daughter she would use the inpatient services at the clinic.

She lives in Heliopolis and it took her 25 minutes to reach the clinic by bus. Her husband is a carpenter.

#### PATIENT 9

Patient 9 is female, aged 48 years and divorced. (veiled Muslim). She has been coming to the clinic for the past 8 years. She is a diabetic and has to come regularly for treatment.

She lives in the neighborhood and heard about the clinic from her neighbors who themselves were using the facility. She also visits another mosque clinic similar to this one which is in area. It takes her 5 minutes to walk to the clinic from her home.

She is very happy with the services. She thinks they are cheap, affordable and convenient for her. She said that she could not afford a private doctor.

She had an x-ray taken yesterday which she had come to collect today. She paid LE 3.00 for the consultation and LE 10.00 for the x-ray. Today she waited 30 minutes to see the doctor.

She has 3 children of which one lives with her. She is a cleaner cum tea lady in a private company. The son that lives with her is a driver but does not have regular work.

## **B. ST. GEORGE CLINIC, HELIOPOLIS**

Interviews were conducted over two separate days.

### **PATIENT 1**

Patient 1 is male, retired accountant (Christian). This is his first visit to the clinic. He heard from friends that this clinic has a good reputation. He lives in the area. He came by taxi and it took him 5 minutes.

He saw the physiotherapist. He did not have to wait, he saw the doctor immediately. He has been seeing a private practitioner about his condition but was not happy with the treatment he was receiving since he was not getting any better.

He is very happy with his consultation today. He felt the doctor gave an excellent check up, gave more attention to him and that the follow up was better. The clinic is much cheaper and he feels that it is affordable to the majority of people.

### **PATIENT 2**

Patient 2 is female, and 44 years old. She has been coming to the clinic for the past one year. Previously she was using another church health facility but was not happy with their services. She came in contact with this clinic through the church.

Today she saw the orthopaedic surgeon. She said the services were excellent. Compared to the other church clinic she was attending the doctors gave more attention and better follow-up. Also there was good inter-communication between doctors in the clinic. If you needed to consult with different specialists they always consulted each other and briefed each other of the case.

She works in the Ministry of Agriculture and is therefore covered by health insurance. However, she chooses not to use the health insurance facilities, and feels they are too slow and difficult to deal with.

She waited 10 minutes to see the doctor today. She come to the clinic in her own car and it takes her 10 minutes. Her husband is in the foreign service and she has lived in many different countries in the world.

### **PATIENT 3**

Patient 3 is female, 44 years old and widowed. She has been coming to this clinic since it opened. She goes to the St. George church. Before she was going to either a mosque or church clinic.

Today she saw the general surgeon. She waited 30 minutes to see the doctor. She likes the service very much and feels it is very affordable. She came by tram and it took her 20 minutes to reach the clinic.

She is a nursery supervisor in the area. She has 3 children, two of whom live with her. One daughter works in a hotel and another is studying at Cairo University.

#### PATIENT 4

Patient 4 is female, 18 years old and a student at the university. She uses the clinic regularly and heard about it from friends. Today she saw the gynecologist. She likes the services very much and says she trusts the doctors. She had made an appointment the night before and therefore did not have to wait to see the doctor.

Her entire family use the facility. She said the clinic was very cheap, although they are not coming because of that. They think the quality of service is very good. The doctors who work here are very experienced and also work in other renowned places. When they require inpatient care they use a private facility.

She lives close to the clinic and although her family owns a car she walked to the clinic today. It took her 14 minutes.

#### PATIENT 5

Patient 5 came for a consultation with the OB/GYN specialist. She is 9 months pregnant. She has been coming to the clinic since the past year. Her first contact was with the orthopaedic surgeon. She liked his treatment and it encouraged her to come here for ante-natal care.

In the earlier stages of her pregnancy she was visiting the clinic once a month. Recently the doctor advised her to come weekly. She plans to deliver at a hospital recommended by the clinic. It will cost her LE 600 if the delivery is normal.

Today she waited one and a half hours to see the doctor. However she said this was unusual and because the doctor was absent for one day.

She does not work. Her husband teaches a technical vocational school. Before she married she lived in the area (5 minutes walking distance from the clinic). But now she and her husband live far from the clinic. It takes her one hour to travel to the clinic by taxi.

### **C. GAMMEYA EL-FATH CLINIC**

#### **PATIENT 1**

Patient 1 is an 18-year old male student. He saw the dentist today. This is second visit to the clinic. He heard about the clinic from a friend who use the facility.

He thinks the treatment given was good and the dentist was very friendly. Before coming to this facility he went to the Heliopolis CCO hospital. He prefers the treatment here, and "trusts" the doctors more. The mosque clinic is also cheaper than Heliopolis hospital. He says that if he requires medical care in the future he will come to this clinic.

He waited 10 minutes to see the dentist. His total bill was LE 12.

His father is a taxi driver. He came to the clinic in his father's taxi and it took him 10 minutes to reach the facility.

#### **PATIENT 2**

Patient 2 is a 28-year old, unmarried female (veiled). She has been using the mosque facility for the last two years.

Today she saw the opthamologist. She has also consulted on previous occasions with other doctors. She thinks the doctors are excellent. She uses no other health facility. For inpatient care she has used the Heliopolis hospital. But for outpatient care she prefers the doctors in the mosque clinic, it is clean and cheaper. She said that when the mosque society open their inpatient service, she would use it should the need for inpatient care arise.

She waited 30 minutes to see the doctor, and felt it was not a long time. Her total bill was LE 7.

She is a teacher at the Ains Shams University. She lives very close to the facility. She came in her own car and it took her couple of minutes.

#### **PATIENT 3**

Patient 3 is a 26-year old, unmarried male. He has visited the clinic on a number of other occasions.

He saw the opthamologist today. He has also seen the clinic dentist in the past. He heard about the facility from a friend who uses the clinic. He uses no other provider. Before this clinic he was going to the government hospital close to his home. He says there is no comparison between the government hospital and mosque clinic. The clinic is cleaner, quality of care better, and the doctors

excellent. He trusts the doctors more in this facility. He feels the fees are very affordable.

He took him one hour by bus to reach the clinic today. He waited about 15 minutes to see the doctor.

He is a motorcycle courier. He studied at the secretarial institute. He lives with his parents.

#### PATIENT 4

Patient 4 is a 17-year old male student. He has been using the clinic for the last 3 years.

He saw the consultant today regarding a pain in his leg. He thinks the clinic is excellent, goes nowhere else and likes all the doctors. The services are cheap. He paid LE 10 to see the consultant. He has been given a prescription and plans to buy the drugs at the pharmacy attached to the society building. He waited 5 minutes to see the doctor.

He lives very close to the clinic. It takes him 3 minutes to walk to the facility. His father is a butcher.

## **ANNEX 2**

### **ORIGINAL SCOPE OF WORK**

#### **A. BACKGROUND**

- (1) Information on current size and scope of sector in Cairo.
- (2) History, growth and development of sector.
- (3) Perceptions of, and support provided to sector by Government, and specifically, the Ministry of Health.
- (4) incensing, regulation and monitoring of sector.

#### **B. SERVICE PROVISION**

- (1) Management and organizational structure
  - i) Management structure, lines of authority and accountability.
  - ii) Relationship between health facility and mosque.
  - iii) Staff employed, qualifications, salary levels with comparisons of those in public and private sectors, and staff motivation.
- (2) The health facility and services
  - i) Range of services provided, volume by type of use.
  - ii) Referral of care.
  - iii) Quality of care - subjective assessment based on clinic environment, staff competence, equipment .
  - iv) Marketing and promotion of services.
- (3) The costs and financing of health services.
  - i) Sources and levels of funding.
  - ii) Range and price of services offered with comparisons with other public and private providers.
  - iv) Basis on which fees are set.
  - v) Pricing policy with particular reference to serving and protecting low-income clients. i.e., are any services provided free or subsidized. If so how is means testing done?
  - vi) Cost breakdown and estimation of unit costs of services. Comparisons with other providers.
  - vii) Assessment of financial status of organization. Aggregate cost, revenue, and surplus/deficit trends.

#### **C. SERVICE UTILIZATION**

- i) Assessment of socio-economic status of services users and other user characteristics, e.g., age, sex, education, profession, etc.
- ii) Exploration of factors leading to choice of health facility, e.g., perceived quality, price/affordability, accessibility, religious affiliation, etc.



- iii) Awareness and knowledge of other providers in vicinity, services provided and prices charged.

#### **D. IMPACT ON WIDER HEALTH SYSTEM**

- i) Impact on other providers (both public and private) in the vicinity, e.g., in terms of changes in service mix, quality of care, or prices as a result of mosque/church clinic.

#### **E. GENERALIZABILITY AND REPLICABILITY OF FACILITIES**

- i) Features likely to affect duplication of such facilities, such as socio-economic status of population, ethnic or religious issues, financial issues (access to capital), management and leadership.

## **ANNEX 3**

### **PATIENT INTERVIEW SCHEDULE**

This is a transcript of the client interview schedule designed by the consultant, and administered by her with the help of the local research assistant to a small number of clients at all four clinic study sites. The interviews lasted approximately 15 to 20 minutes with each client. Clients were interviewed after their consultation with the doctor.

The broad aims of the interviews were:

- to determine the socio-economic status of clients and assess affordability
- to explore the factors underlying their choice of the facility
- to assess clients perceptions of quality of care received and patient satisfaction

A fairly unstructured, open-ended approach to interviewing was favored. The topics around which questions were asked are outlined below.

At the start of each interview it was explained to clients that the purpose was to try and understand why people come to use the facility. That we were interested in a number of issues like: how people learn about the clinic, what they think of the treatment they receive, how things could be better in the clinic.

Complete anonymity was stressed - we did not wish to know their names. Interviews ended by asking whether they had any questions they would like to ask the interviewers.

#### Questions/Topics

1. Have you or any other members of your family been to the clinic before?  
How many times?
2. What services have you received today, and in the past?
3. Personal data, such as sex, age, education, occupation.
4. How long did it take you to reach the clinic today? Did you come directly from home? If not how long would it take if you did? How did they come, by walking, bus, taxi? (if from a far distance explore why did they not use another closer provider, (e.g., government or private?))

5. How long did you have to wait today to see the doctor?
6. Have you received services from other providers in the past? If so, why did you choose/change to this clinic, and how did you hear about it, e.g., from friends, family, mosque itself, referral? If, referred from where?
7. If they have used other providers, explore how this clinic compares in terms of quality e.g., staff attitudes, waiting time, privacy, general environment and cleanliness, availability of drugs and other commodities, and charges? Attempt to assess whether religious affiliation is an important factor in choice of facility.
8. Once onto topic of fees attempt to assess ability to pay. Ask about economic status, e.g., occupation, (if woman not working then ask what the occupation of husband is) how many people working in household. Do they feel the price they pay is reasonable. Awareness of charges of other providers for similar service, and comparison with this clinic.
9. If they could make suggestions to the management of how to improve the services what would they suggest?
10. Do they avail of any other mosque/church services?